

To Stay a Soldier

CHUCK CALLAHAN

“Doc, if you try to take me out of the 82d, you’ll be hearing from my congressman.” The young soldier with tattooed arms strained against the bedrails, his eyes searching the doctor’s face above, his twisted, purplish leg surrounded by a black steel cage of bolts and rods that held his shattered bones together.

He was one of many men and women wheeled from surgery to therapy to their rooms and back again, in a circle of hope and pain on Ward 57 at Walter Reed Army Medical Center. I was so new in the job as Deputy Commander for Clinical Services (Top Doc) at the medical center that I had not finished orientation. I met this soldier on one of my first daily walk-rounds through the wards of wounded soldiers. He had been severely injured several months before. Every new orthopedic trick known was being applied to save his injured limb and return him to the ranks. In any other war, the injury he had sustained would have led to amputation, a medical disability board, and a rapid transition to care in a Department of Veterans Affairs (VA) facility. But not this war. This soldier was a soldier by choice. He did not want to leave his unit, his fellow soldiers, and the life he had found in uniform. I did not suggest a transfer to him again.

My job at Walter Reed was to ensure that soldiers received the best, safest medical care America had to offer. My boss outlined a two-pronged approach to the tasks at hand. First, the hospital had to continue to exceed the standards of the Joint Commission on Accreditation of Healthcare Organizations. Second, working with the other deputy commanders, I was to address the problem of the “medical hold” population.

Soldiers who were receiving treatment at Walter Reed were generally transitioned into the “Medical Hold Company” for purposes of

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military accountability and medical continuity. Before the war, there were about 100 soldiers in the medical hold unit. When I joined the staff after Thanksgiving 2005, there were more than 800. Not all had been formally assigned; some were simply “attached” and remained on the rosters of their former unit. The staff assigned to direct their care, including company commanders and platoon sergeants, had come from positions at the hospital.

A significant number of the medical hold soldiers were men and women caught in the mire of the Army’s archaic physical disability evaluation system. This system’s disability rating and arduous compensation processes were more than half a century out of date. It had created a subculture of soldiers undergoing physical disability evaluation who could no longer perform their duties as soldiers (or, in the case of reservists and guardsmen, their civilian jobs), but whose Army disability rating would not provide enough income to support them and their families.

During the year that followed, we made some progress improving the coordination of care for patients who had transitioned from the hospital beds into an “outpatient” status—staying in hotels, barracks, and temporary housing arrangements on the 114-acre post and in the surrounding community. We had begun to consolidate the multiple agencies and activities responsible for the soldiers’ care and to organize the bewildering business of military disability processing. Wounded and ill soldiers were being routed to other medical facilities across the nation to better balance workload and resources. Our efforts were, unfortunately, not enough.

Beginning 18 February 2007, a series of Pulitzer Prize-winning articles in *The Washington Post* highlighted the challenges still plaguing some of the veterans receiving outpatient care at Walter Reed. The conditions reported in the three articles, and the media attention that followed, captured headlines around the world. The ire of the American people was raised at the thought of veterans being subjected to “squalor” and “mind-numbing bureaucracy.” In the following 40 days, the medical center was subjected to the glare of negative national attention and weathered the loss of its Commanding General, the Army Surgeon General, and the Secretary of the Army. The Georgia Avenue facilities were inspected in an unannounced survey by the Joint Commission on Accreditation of Healthcare

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Organizations, countless generals, Cabinet secretaries, more than 150 members of Congress, and the President.

Walter Reed's leadership had to admit that, despite our efforts, some soldiers still suffered in a frustrating, difficult to negotiate system. That system failed those soldiers and their families. The hospital staff failed them. Among staff members, the *Post's* articles evoked an incredulity shared with the American public, and when we were honest with ourselves, we asked along with the public, "How did an organization that was the most successful in history at the point of a soldier's injury, break down when the soldiers reached the other end?"

The articles suggested an even deeper tension. The challenges that developed at Walter Reed were the result of a subtle but significant change in what it means to be an American soldier, fighting this war and caring for soldiers at this point in history. The failure to recognize and appreciate such differences in wounded soldiers, and perhaps even in ourselves, explains at least in part how the conditions developed.

The most gravely ill and injured soldiers still begin their time at Walter Reed on the inpatient units. Visitors to the hospital enter the same doors as a war-wounded veteran. As patients are wheeled or walk through the two-story open lobby, a large banner hanging below the service flags welcomes them to Walter Reed with the motto that reflects the hospital's mission statement: "We Provide Warrior Care."

In more than a century of service, Walter Reed has developed a single focus, crystallized by the current conflict. For five years, anyone who wondered about the medical center's mission needed only to walk the halls on any day of the week and encounter scores of young men and women recovering from major limb amputation and other injuries. Every first-time visitor leaves with the same indelible impression of the cost of the conflict. An Iraqi reporter asked whether it was difficult for staff members to stay focused when they were so far from the combat zones. Her visit with the staff and patients illustrated for her the reality that there may be no location in the United States where one is closer to the war and its impact than Walter Reed.

This mission focus helps explain why the *Post* articles struck the Walter Reed community so hard. Both individuals and organizations can derive meaning and significance from a central, unifying purpose. Walter Reed has a century-long history. The institution's staff has cared for the nation's wounded through five previous wars and has for many years derived meaning from its position as the primary center for the care of America's most horribly wounded and most desperately ill. Walter Reed came to define itself by that role—perhaps at the unfortunate expense of other cat-

egories of patients. The articles' allegations, and the other media attention that followed, cut to the very heart of the hospital's mission and the meaning staff members derived from it: how we viewed ourselves as "the home of warrior care."

Although Americans have historically mistrusted professional soldiers and a standing army, in the past century the American soldier and the soldier's experience have come to symbolize sacrifice and significance for the nation's citizens. After World War I, veterans were in part responsible for keeping alive the imagery of war in American culture. The sense of national loyalty and unity experienced during wartime was perpetuated by parades and military ceremonies. The Great War was depicted as a process that had somehow improved those who fought in it. The idea developed that those who had served in the war were a group set apart; a group owed benefits and special services.¹

In the ensuing decades, war was increasingly used as a metaphor to galvanize the American will. In 1933, President Franklin Roosevelt depicted the Great Depression as a "war against the emergency," and after World War II, Americans adopted a vision of war as the model for economic success and productivity. Eventually, the "myth of war," with its concepts of loyalty, victory, promise of security, focus on an enemy, image of national effort, and implications of unity, evolved as an important model to explain American behavior and perspective. The popularity of soldiers reflected this image.² During times of war especially, the soldier becomes the "exemplar" of America's highest ideals.³ Something in the American character flourishes during wartime.⁴

This is the Army the Walter Reed ill and wounded had joined. It was the Army they were loath to leave. Retired Air Force General Johnnie Jumper tells the story of walking through a crowd of recruits recently graduated from basic training. He asked a young graduate how she felt. "Sir," she said, "for the first time I feel as though I am a part of something bigger than myself." For many members of the millennial generation (born between 1980 and 2000), military service, the chance to serve their country at great personal risk and sacrifice, is the most significant thing that they have done.

Dozens of young soldiers sent me pictures of Iraqis with ink-stained fingers after the election in January 2005. "This is what it's all about," one e-mail read. A soldier from Minnesota at Walter Reed had lost both legs in Iraq. He told visitors more than once, with his beautiful young wife and children standing by, that he would gladly go back and do it again.

He is not alone. As of July 2009, a total of 913 soldiers, sailors, airmen, and Marines have suffered major limb loss in Operations Iraqi

Freedom and Enduring Freedom. Many have lost more than one limb. More than one hundred have remained on active duty despite their injuries. Dozens have returned to serve in Iraq and Afghanistan again.⁵ More than half of all soldiers evacuated from the battlefield for injury or disease and transported to medical facilities in the United States return to duty.⁶ Clearly, something keeps these young people coming to and staying in military service.

Victor Frankl, a psychiatrist who survived the German concentration camps at Theresienstadt, Auschwitz, and Turkheim, believed that “man’s search for meaning is the primary motivation of his life.”⁷ He proposed that “at any moment, man must decide, for better or worse, what will be the monument of his existence.”⁸ The notion of significance through service is not a new one. Dostoyevsky’s Ivan Karamazov tells his brother Alyosha, “The mystery of human existence lies not in just staying alive, but in finding something to live for.”⁹

For those working at Walter Reed, the monument of our existence was the care of soldiers. This is why the criticism of the media, politicians, and the American people was so difficult to hear. We had chosen to care for soldiers, their families, and the systems that provided for care. And those systems had failed for some patients. Those leaders who lost their positions in the weeks after the *Washington Post* articles lost a part of that “monument” that will never be recovered.

For soldiers and those who care for soldiers, military service is something to live for. It is a source of meaning and long-lasting significance. It is not uncommon for those who leave the military to talk about missing the camaraderie; the basis of this camaraderie is unity around a single purpose. Soldiers are drawn to this unity of purpose, and they suffer when it is gone.

It is likely that no one will ever completely understand the circumstances that led former Army Private Joseph Dwyer to end his life in July 2008. Dwyer was the young medic made famous by Warren Zinn’s picture taken in March 2003 during the first weeks of the war, in which he was shown with an anxious face carrying a young Iraqi boy with an injured leg. The soldier and the photo instantly became iconic symbols of American forces in Iraq.

Military service in Iraq held great significance to Joseph Dwyer. He wrote to Zinn in December 2004, within a year of his return from combat, “When I first got back I really didn’t want to talk about being over there to anyone. Now looking back on it, it’s one of the greatest things I’ve ever done.”¹⁰ There is no doubt that Private Dwyer suffered horribly after his return from Iraq. Newspapers report that he struggled with post-traumatic stress and adjustment disorders.

Jeffrey Sonnenfeld and Andrew Ward, writing about leadership in crisis, observed that “. . . the most common theme in the research on resilience is the necessity of a core sense of meaning in the person’s life.”¹¹ Perhaps some of what Private Dwyer suffered, and what other soldiers suffer as well, is the pain of the poignant loss of meaning and purpose that accompanies the transition from “in the service” to a life where service is harder to define. Possibly this loss of meaning weakens the soldier’s resilience when he or she needs it most.

It is difficult to completely explain the shortcomings that evolved in regard to the care of some of the recovering soldiers at Walter Reed. Although the medical center began its role in the Global War on Terrorism on 11 September 2001 with treatment of patients wounded in the Pentagon attack, pressures facing the institution preceded the war. Frequent turnover of key leadership positions and an aging hospital infrastructure led to a gradual decline in the facility’s condition. Housekeeping, maintenance, and upkeep were taxed in a two-million-square-foot, 30-year-old patient care facility located on a rapidly decaying century-old campus.

Numerous distractions limited the hospital leadership’s ability to maintain a strategic perspective and to appreciate the subtle change in the attitudes of the wounded soldiers cared for there. Despite its ongoing role as the primary receiving hospital for the war, Walter Reed was placed on the Base Realignment and Closure (BRAC) list in May 2005. Once the post was added to the BRAC list, obtaining funds for the capital improvements necessary to continuously upgrade, expand, or improve ambulatory care for wounded soldiers and other patients became a challenge. Leaders were distracted by the process of integrating Walter Reed with the National Naval Medical Center at Bethesda. It was increasingly difficult to recruit and retain the civilian workforce, which comprises more than half of the medical center staff.

In this current conflict, the number of service members who have died of wounds has been the lowest ever recorded. Nearly 95 percent of battle-wounded soldiers survive. In addition to severe injuries and major limb amputation, up to 40 percent also suffer from traumatic brain injury, and significant numbers suffer post-traumatic stress disorder and a range of other psychiatric afflictions. At Walter Reed, these wounded soldiers recovered slowly, and in many cases despite their passion to remain on active duty, many reached a point where they faced the inevitability of entering a cumbersome disability evaluation system that had not been overhauled in more than 60 years.

Former Secretary of Defense Donald Rumsfeld said, when challenged about the Army’s preparedness for the Iraq conflict in the summer

of 2004, “You have to go to war with the Army you have, not the Army you want.”¹² The Army medical system went to war with what it had, and the tremendous success realized was the lowest died-of-wounds rate in history. Long-term rehabilitation of these severely wounded soldiers was another matter.

Military planners had not anticipated that the war would last five years, nor did they anticipate all of the long-term rehabilitative-care needs of the severely wounded who survived. More importantly, no one anticipated that so many soldiers would be resistant to transitioning out of the Department of Defense’s healthcare system and into the VA’s—that so many would opt to stay on active duty for as long as they could.

The nation went to war with an all-volunteer military force. Many of the young soldiers who were wounded and facing the end of their military career had spent their entire adult lives as soldiers. They were not only reluctant to give up being soldiers; many had no other adult identity to which they could return.

In the years leading up to the *Washington Post* articles, military leadership failed to recognize and respond to the strategic shift that had occurred as the Walter Reed campus slowly evolved from being an acute, specialty care hospital to also being the most important rehabilitation center in the Department of Defense. When the population grew at Walter Reed, with patients staying sometimes for years, senior leadership failed to appreciate and adapt to the significance of this strategic mission change. Long-term rehabilitation was traditionally the realm of the Department of Veterans Affairs. The young members of America’s volunteer Army resisted retirement and transfer to the VA. They had found a life that provided meaning. They wanted to stay soldiers.

Since the *Post* articles, progress has been made in the care of wounded, rehabilitating soldiers through the creation of a new system of medical management for ill and injured soldiers. Across the nation, in an initiative begun at Walter Reed, “Warrior Transition Units” staffed by specially trained combat-veteran officers and noncommissioned officers now have command and control of the “warriors in transition”—long-term patients at military treatment facilities. In the words of Brigadier General Mike Tucker, a career armor officer who became Walter Reed’s deputy commander at the height of the crisis, “being a patient is no longer a status but a mission, a mission to heal.”

Soldiers are supervised by noncommissioned officer squad leaders who make sure the patients attend to their “soldier” duties as much as their conditions allow. These noncommissioned officers also make sure that patients get to their medical appointments and keep a close eye on the sol-

diers at increased risk: those receiving extensive long-term narcotics, with psychiatric conditions, or traumatic brain injury. Their care is supervised by the second two elements of the “triad” of care: nurse case managers and primary-care physicians who are specially trained and solely dedicated to the management and coordination of these patients’ care. The number of squad leaders, case managers, and physicians supporting each unit is based on the population of soldiers assigned. The ratio of these support personnel to soldier/patient is closely monitored.

Barracks for soldiers who are assigned to these units have been renovated and refurbished, often with computers, television, and Internet access to encourage participation in the myriad online educational opportunities offered to service members. Soldiers are expected to work in part-time positions as their conditions allow, or to take classes. New housing complexes are planned and funded for many posts. Every post also has a centralized Soldier and Family Assistance Center, where services including military pay, personnel, counseling, and family support are co-located for convenience and efficiency.

There are new processes for moving patients through rehabilitation, to VA facilities, and back to the military to match the Army’s needs and, importantly, the desires of the soldier. In a pilot project begun at Walter Reed, the military and VA disability systems have been combined into a single process. Lessons have been learned from this pilot program, though the feedback from soldiers who have been through it has been mixed. The process still takes a long time (more than 200 days from start to finish), is complex, and inconvenient; some parts of the evaluation are completed at military facilities and some at VA facilities. The two systems have different electronic medical records that do not “talk” to each other. There is still much work to be done.

These new processes are detailed in the Army Medical Action Plan, a set of directives developed in the weeks after the *Washington Post* articles. The plan has been implemented across the nation at every major Army post. Included are specific outcome metrics monitored at every level of command up to the Army Chief of Staff. At regular intervals, experts from every discipline engaged in the care of soldiers meet to review and revise the standards. With experience, the standards and metrics have been adjusted and modified to better meet the needs of this unique patient population.

As a result of these and other initiatives, the two-thirds of patients admitted to Warrior Transition units across the nation who return to duty represent the equivalent of two complete combat brigades every year, many of whom are senior noncommissioned officers or career officers.¹³ Their re-

covery is an enormous boost to an already overtaxed Army by keeping the most skilled and experienced soldiers in the military. And it allows those whose lives have become defined by service to continue to serve.

The Walter Reed commanding general who was relieved shortly after the *Washington Post*'s expose admitted to the House Committee on Government Reform, "It is clear mistakes were made We can't fail one of these soldiers or their families, not one, and we did. We did not fully recognize the frustrating bureaucratic and administrative processes some of these soldiers go through. We should have."¹⁴ What is more, the process of medical treatment and evaluation did not accommodate the degree to which soldiers wanted to stay soldiers and did not resource the systems needed to allow them to do so.

Perhaps we have also avoided answering more difficult overarching questions. For example, what of the more than 85 percent of soldiers with major limb amputation who do not stay in the military? What happens to all of the other injured soldiers who do not choose to stay soldiers? How well are these soldiers followed over time—after they leave Walter Reed and the other military facilities and return to communities far from Army posts or VA clinics? How well does the system support these veterans as they find meaning and significance in American culture as spouses, parents, co-workers, and citizens?

It is possible that the United States has entered an era when a national draft is impractical; too few Americans between the ages of 18 and 24 are physically or emotionally able to serve in the active-duty military. Perhaps "soldiering" in the twenty-first century is too complex a skill set to be casually learned by the unwilling through relatively brief basic and advanced training. In such an era, it is clear that the nation cannot fight without its citizen soldiers, the Reserve and National Guard. Will these organizations be able to recruit and retain soldiers who are willing to commit their future to a military health system that by law cannot care for them once they leave active duty, and a military disability system that will not compensate them fully for injuries or illnesses they sustain while serving?

Despite the unanswered questions, in a year's time, one of the nation's largest and most complex medical organizations has executed a foundational about-face and has led the entire Army Medical Department, Army, and Department of Defense in embracing the mission for the care of acutely wounded soldiers on the battlefield, as well as for chronically recovering soldiers at home. The system has been shaped by Americans to better care for soldiers who are, in the first place, volunteers.

Soldiers, those who care for soldiers, and the significance they find in service were inspirations for President Obama's call to a life of

meaning for all Americans. “As we consider the road that unfolds before us, we remember with humble gratitude those brave Americans who, at this very hour, patrol far-off deserts and distant mountains. They have something to tell us, just as the fallen heroes who lie in Arlington whisper through the ages. We honor them not only because they are guardians of our liberty, but because they embody the spirit of service; a willingness to find meaning in something greater than themselves.”¹⁵

The words of an earlier President serve as both the inscription on this monument of existence and a catalyst for continued improvement in the care of soldiers. Abraham Lincoln said, “Let us strive on to finish the work we are in, to bind up the nation’s wounds, to care for him who shall have borne the battle.”¹⁶ As new and more complex injury patterns emerge, it is clear that the binding of wounds, both those that are visible and those that are not, and the caring for America’s battle-worn from this war is only beginning.

NOTES

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5. Author’s interview with Charles Scoville, Director of Military Amputee Program, 1 February 2009, updated data by e-mail to author, 6 July 2009.
6. Michael Carino, “Warrior Transition: Length of Stay in Process,” Department of the Army Office of the Surgeon General, 31 December 2007.
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